AUTHORIZATION FOR RELEASE OF INFORMATION

To Whom It May Concern:

I, _____hereby authorize any hospital, medical practitioner, clinic, other medical or medically related facility, pharmacy, insurance company or Government Agency to disclose or furnish to Activa Benefits Services, LLC, its subsidiaries or representatives, any and all information with respect to any illness, including mental illness, drug/alcohol abuse, injury, medical history, consultations, prescriptions, treatments or benefits, and copies of all applicable records that may be requested for myself and/or any of my dependents.

The information provided to Activa Benefit Services, LLC, its subsidiaries or representatives is to be used solely for the administration of claim(s) made by the undersigned. A photo static copy of this authorization is to be considered as valid as the original and it is effective for the duration of the claim.

PATIENT: _____

_____ _____

Signature of Authorization Date

(A true copy of this authorization is available to the employee at any time upon request.)

P.O. Box 37 Farmington, Michigan 48332
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